Health Homes

Early Implementation Successes

"We've discovered it's not about
what's billable;
it's what's needed."
~IDD HHP Nurse

AD ASTRA PER ASPERA
KanCare

Health Homes for individuals with Serious Mental Illness (SMI) went live in July of 2014 and members began receiving services in August of 2014. There are approximately 34,000 members currently being served by the SMI Health Homes. Though an individual's SMI diagnosis leads to their eligibility for the program, Health Home services address far more than their qualifying diagnosis.

The aim of Health Homes is to address the "whole person" through the use of 6 Core Services:

* Comprehensive Care Management
* Care Coordination
* Comprehensive Transitional Care
* Health Promotions
* Referral to Community Supports and Services
* Member and Family Support

These services are in addition to the services that members currently receive through KanCare.

This booklet contains some early implementation success stories. Where appropriate, we have changed members' names to protect their identity.

Connections for Life, High Plains Mental Health Center in Hays, Kansas

Connections for Life: Rethinking How SMI Impacts Daily Life

The most rewarding experiences we have encountered here at Connections for Life come from making a difference in the lives of our members. People who do not have a severe mental illness often take the personal ease of daily tasks for granted. Not thinking about how anxiety provoking it can be to call a doctor's office, make a dental appointment, pursue learning opportunities within the community, seek support for mental illness, or manage chronic illnesses. For most people these things are part of "normal" life and we make sure they are accomplished. As we have begun working in the Health Home, it forced us take a closer look at these routine tasks such as: calling a dentist and being told that there is a two-month waiting list for the next opening; a nurse asking you to describe your symptoms when trying to make a doctor's appointment; walking into the first day of class or group, not knowing anyone; and the stress of having a minor illness and not knowing the most efficient way to treat it. All of the above actually are a little stressful when we think about it. We attempt to walk in the shoes of our members, realizing that if it is stressful for us, it is daunting for an individual with severe mental illness.

"...if it is stressful for us, it is daunting for an individual with severe mental illness"

We have encountered people who had not seen a dentist in almost a decade and made appointments for them to have multiple abscessed teeth pulled. We have accompanied members to Vocational Rehabilitation interviews, providing a sense of hope and accomplishment. We are scheduling primary care appointments and following up to make sure these members understand how to manage their chronic conditions. We are often attending these primary care appointments with our members and reinforcing the physician's directions. We are referring to grief support groups, food banks, and parenting classes. We have attended health literacy workshops, and are using the curriculum to teach our adult members what to do when their child is ill. Our nurse care coordinator has a weekly support group, which provides health education to our members with various chronic conditions, and also includes a walking/exercise group. We enjoy seeing the hope in our members' faces as we teach them that taking preventative steps to become healthier is not only feasible, but rewarding as well. We have realized that anxiety contributes so much to the lack of preventative health care in these people, and we are helping them to overcome this barrier.

Connections FOR LIFE

Katrece: From the Hospital Back to Her Home

In Katrece's words:

Angela has helped throughout my whole journey. She came to visit me in the hospital when nobody else did. Meeting with Angela felt sincere and that she wasn't just doing a job, but doing it because she actually cared. Angela helped me get in to mental health counseling and even attended my first session with me because I had anxiety about going to the appointment. When I feel down, I feel secure in calling Angela. She is an uplifting person. I truly feel Health Homes is a good program. When I was really sad and depressed Angela provided comfort and gave me hope. Angela has shown sympathy which shows me there are truly good people in the world. Every time we have met, Angela has been honest and genuine and I respect that. Angela helped me build my confidence up when I was feeling like giving up. Angela has helped me start to gain acceptance over my month long hospital stay by being supportive and helping me get in to therapy and mental health medication appointments. Angela has never turned her back on me ever at my worst. I hope Angela remains a support. I truly feel blessed to have these services in my life when I needed them the most.

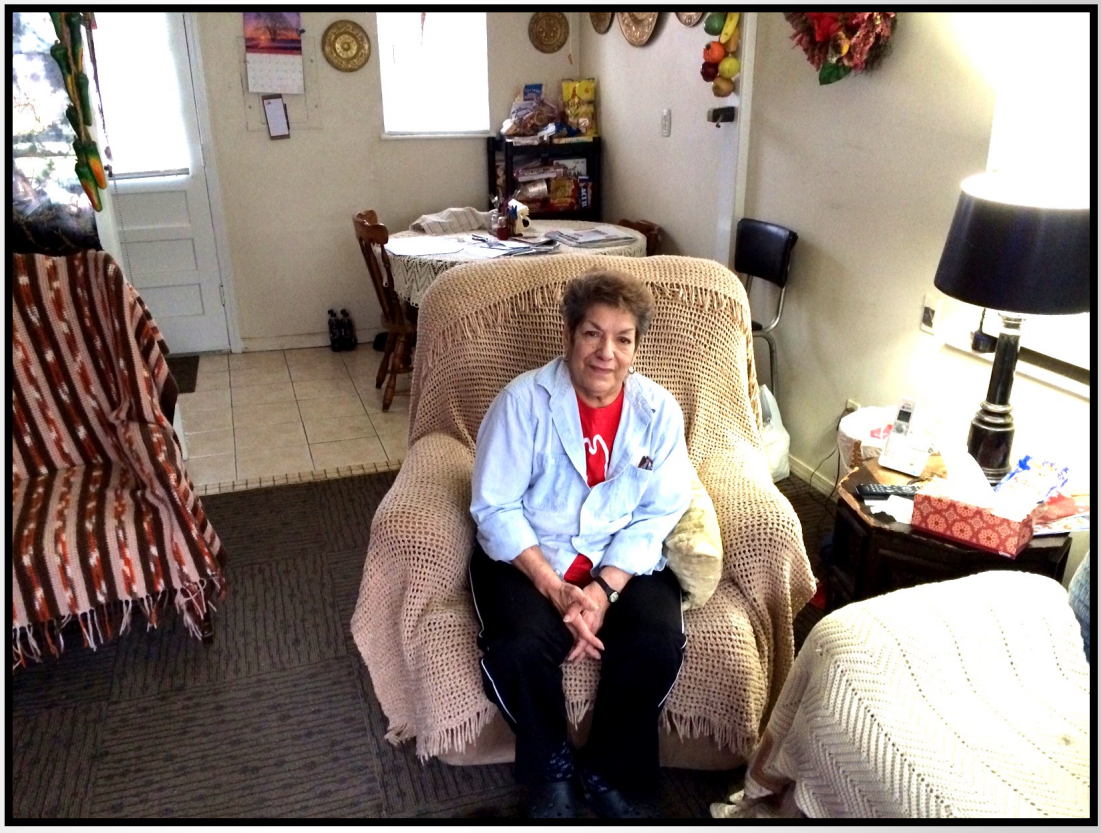
In Angela's words:

"...she wasn't just doing a job, but doing it because she actually cared"

I met Katrece in August at KU Medical center where she had been inpatient for a month due to Crohn's disease. She weighed 88 pounds when she left KU Medical Center and came home to Topeka to stay with her mother because she was unable to care for herself or her children at that time. I met with Katrece on a weekly basis at first because she appeared to have experienced trauma from being hospitalized and alone in the hospital for so long. Our sessions were often met with Katrece being tearful and hopeless over the weight she had lost and the constant pain she endured at that time. She was unwilling at first to see the need for therapy and mental health medication. Over time and after several meetings, she agreed to go to therapy and see a psychiatrist for medication. I made the appointments for her, made sure she had transportation and met her at her initial appointments with her therapist and psychiatrist as she was expressing severe anxiety over seeing any more doctors. I provided coping mechanisms for Katrece to help her reduce her frustration with those trying to help her. I coordinated her medical care with her nurse navigator through Cotton O'Neil to ensure she maintained her appointments. I worked with her mom and caretaker at the time to discuss coping mechanisms to use when Katrece and her mom would get in arguments.

This December, Katrece is living back in her own home, taking care of her two children and making amends with her estranged husband. She has her pain under control at this time. She has also been able to maintain her therapy appointments and reschedule them if she is unable to make them. In the past she would just stop going and not reschedule. She told me she is now up to 118 pounds. When I saw her this month, she met me at her front door with an amazing smile on her face. Katrece has come a long way from the person I met in August. She appears more optimistic about her future and has a stronger outlook on life.

Ramona: How Health Homes Treats the "Whole Person"



Ramona is 77 years old and lives alone in a single family home in Kansas City, Kansas. Through the assessment, staff at Mirror, Inc. were able to identify areas of need in Ramona's life that could affect her overall health and well-being. Ramona said she did not always have reliable transportation to medical appointments. She also reported that she had fallen in the past due to blackouts related to poor diabetes management.

We worked together to identify a routine she completes every morning; after breakfast she takes her dishes to the sink and likes to look out the window into her backyard. We put a sign up in the window to remind her to take her insulin.

She was not aware of the KanCare transportation benefit; we informed her of this service and worked with her to set up transportation to the remainder of her medical appointments. We also worked to get Ramona on the Frail Elderly Home and Community Based Services (HCBS/FE) waiver so she could acquire an in-home care giver. Due to Ramona's limited mobility from a fall that resulted in a broken pelvis, the caregiver would assist with cleaning in her home and cooking meals.

"It's more hands on, one-on-one."

Ramona also expressed ongoing stress and worry related to her two children. She reported that her son had a relationship with alcohol and it had taken over his life. She expressed strain in her relationship with her son and daughter. We gave Ramona contact information for In Home Family Therapy Associates. They are able to meet with KanCare members in their home and provide counseling services. We also worked with Ramona to get her KanCare benefits reinstated.

When asked how the Health Home program has benefited her Ramona stated, "It's more hands on, one-on-one. Maybe you don't even know what's out there to help and they can help find it. There are a lot of options that I know are there for me if I need to use them. Without this program I would have lost my Medicaid. I am very thankful about that."

Sunflower Diversified Services, Great Bend, Kansas

Sunflower Diversified Services is a non-profit organization located in Great Bend, Kansas providing services for both children and adults with developmental disabilities. Sunflower had its beginning in 1966 when family members and other community citizens established a program for children, and in 1969, a program for adults with disabilities was started.

Sunflower remains the only full service provider in this area that offers programs for all ages, from birth through retirement.

Sunflower's mission is to assist individuals in becoming as independent as possible, and to maintain that independence as long as possible. Sunflower believes that a disability should never prevent a person from living the most fulfilling life possible; nor should that individual ever shy away from participating in everything the community has to offer.

"One of the benefits of providing Health Home services has been that case managers have been able to focus on what the person needs instead of what is billable as Targeted Case Managers."

Sunflower is proud to include Health Homes as part of the services offered, not only to persons with disabilities, but also to the community. Our mission for assisting independence and assisting people to live fulfilling lives carries over to the Health Home program. We pride ourselves on our collaborative and creative team of case managers, nurses and support personnel who assist clients in identifying needs, setting goals and then working side by side with the client to achieve those goals.

One of the benefits of providing Health Home services has been that case managers have been able to focus on what the person needs instead of what is billable as Targeted Case Managers.

SERVING CHILDREN & ADULTS WITH DISABILITIES
Sunflower
DIVERSIFIED SERVICES, INC.
THE CHOICE FOR GROWTH
www.sunflowerdiv.com

Sunflower Diversified Services Health Homes has demonstrated tremendous success in helping people achieve healthier lives and the team is looking forward to continued success in making a difference!

Kenny: Health Homes Help Protect Members From Exploitation

Kenny began receiving Targeted Case Management services in September 2012. He is diagnosed with Mild Intellectual Disability, Intermittent Explosive Disorder and Adjustment Disorder with Disturbance of Conduct. He was found naked in his front yard, unresponsive due to inability to manage his diabetes in November 2012. He was unable to stop family members from exploiting him, unable to manage his finances and unable to maintain employment because he couldn't follow instructions or keep up with the pace. There was a risk of homelessness. There were continued concerns about lack of diabetic monitoring, not keeping appointments and continued exploitation by family and others.

Kenny was admitted into Health Home services with Sunflower Diversified Services, Inc. in September 2014. We discovered during development of his Health Action Plan that he was unable to read and write, but he is able to read and write numbers. Staff are now taking him grocery shopping to help him choose healthy foods in appropriate amounts. We are doing routine house checks to make sure that he is not overstocking on certain items or buying foods he doesn't need that will spoil. We are creating a "shopping notebook" with pictures to help him identify what brands and items he needs from the store. We are slowly moving him towards independence. Staff began by taking him to the grocery store, but now he is meeting them at the store. Eventually he will be going alone.

"While Health Home doesn't provide all the services Kenny needs, they have reduced the risks in his life significantly."

Kenny turns in his glucose readings weekly, so they can be monitored. We are working on nutritional training, making healthier selections, portion sizes and weight management. Health Home staff remind and transport him to all psychiatric and physician appointments. We also attend appointments with him. Recently we discovered that he was allergic to grapefruit and broke out with a rash. In the process we were able to identify a possible citrus allergy that was resolved by avoiding citrus foods. This prevented two visits to the ER in a two week period.

After the initial admission into Health Home, staff was able to identify more exploitation that required law enforcement involvement. While Health Home services don't provide all the services Kenny needs, they have reduced the risks in his life significantly.

Desiree: Health Homes are Making a Difference!

Neoma Felps of Valeo writes: In the short time I have been a Health Home Comprehensive Care Coordinator, I have had the opportunity to make an impact in many people's lives. One big success involves Desiree, a woman who had not had an eye appointment in several years. Desiree had broken her eye glass frames and had tried to replace the lenses of an over the counter pair with her own prescription lenses. When she discovered they would not fit the correct way, she turned them upside down to get them in.

Desiree's guardian, Linda, was unsure of how long she had been wearing them this way. Additionally, Linda reported that Desiree had been having "visual blackouts" in which her vision would turn completely black for a period of time. I worked with Linda, who has been by Desiree's side from the very beginning to assess what could be done to help Desiree. Given the situation, one of our first goals was to get Desiree into an eye doctor. After this appointment, I learned that the doctor found a suspicious "spot" on Desiree's eye and had referred her to an eye specialist.

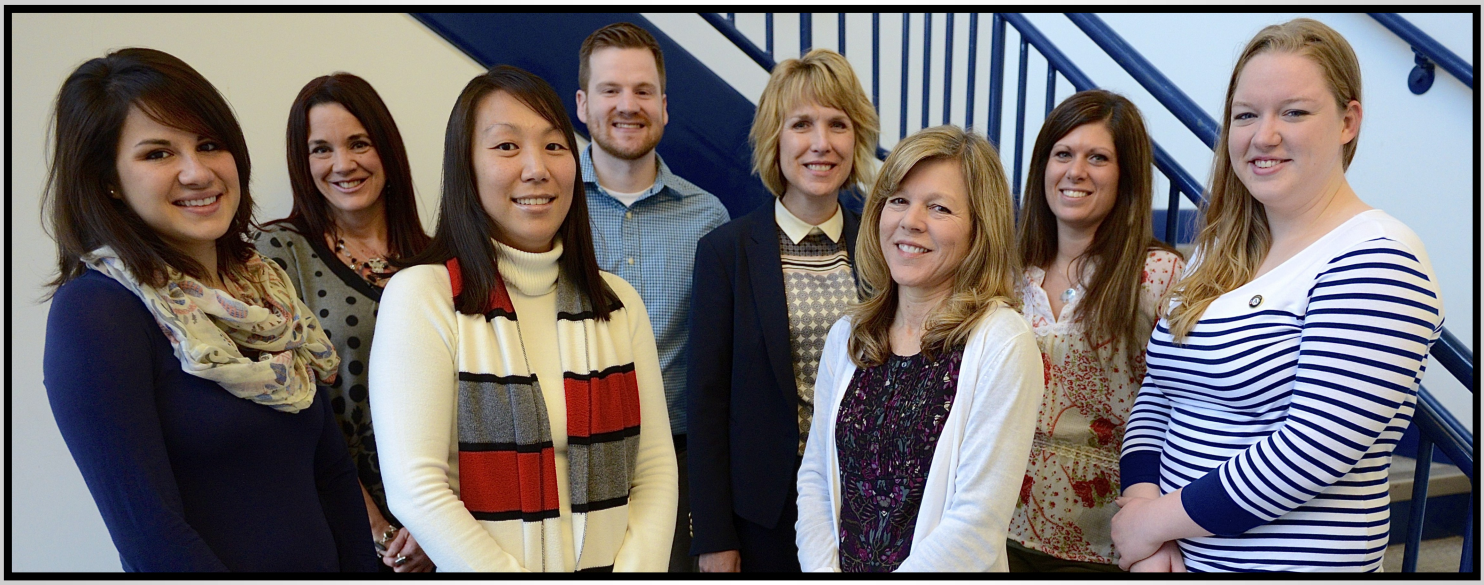
The eye doctor was concerned because the "spot" could be a an indication of a tumor. I helped get follow-up appointments and an MRI scheduled for Desiree. The MRI results showed that the "spot" was not cancerous, but was caused by swelling of the optic nerve (pseudotumor cerebri). The most common cause of this is increased spinal fluid pressure which can lead to visual changes if successful treatment is not given.

We were able to get Desiree new eye glasses and I helped schedule an appointment for Desiree with a neurologist. The neurologist prescribed medication to decrease the production of spinal fluid and ordered a lumbar puncture to relieve some of the excess fluid. Desiree noticed an immediate improvement in her vision after this procedure.

Desiree says of Health Homes: "If what I went through will help others, then I'm happy to share."

Desiree and Linda were so very appreciative for my help in setting up the eye appointments. Desiree has stayed strong throughout the entire process and wanted to share her story saying: "If what I went through will help others, then I'm happy to share".

This story reminds me of why I am here: to continue to help consumers strive as individuals and to make differences in their lives. One step at a time!



Health Connections Health Homes, Bert Nash Community Mental Health Center, Lawrence, Kansas

Marc: Getting Another Chance through Health Homes

Marc is a member in his late 50's who has been drinking for 30+ years. Marc has been banned from the homeless shelter and has been disowned by family. Marc has had numerous medical issues surrounding his drinking, such as broken fingers and head injuries due to frequent falls. Marc went to inpatient treatment around 10 years ago and has struggled with relapse. Marc has been homeless for the last month and has been sleeping in the park. Marc was originally scheduled for inpatient treatment at New Chance on November 26th but missed his ride. The Health Home care coordinator contacted New Chance and was able to reserve Marc's bed for December 4th. The care coordinator then spoke to the housing team leader at Bert Nash. The housing team leader agreed to assist with paying for Marc to stay at a hotel until he went to New Chance on December 4th. The care coordinator then contacted Marc's MCO for transportation services and scheduled Marc to be picked up on December 4th. The care coordinator spoke with Marc's Bert Nash case manager who graciously agreed to ensure that he did not miss his ride on December 4th to New Chance. Marc left for treatment at 7:30AM on December 4th and the care coordinator spoke to New Chance that afternoon to ensure Marc checked in. The care coordinator also spoke to Marc that night and provided him with encouragement and support. Marc will be in treatment for 28 days. The care coordinator, along with Marc's Bert Nash case manager continue to be in contact with New Chance and will follow up throughout his stay in treatment.

"The goal of the health home is to decrease inpatient stays, decrease ER visit and decrease symptoms related to chronic conditions," team leader Amy Warren said.

Bert Nash
COMMUNITY MENTAL HEALTH CENTER
Health Connections
A HEALTH HOME PROGRAM

COMCARE Health Home, Sedgwick County, Kansas

Health Links of Sedgwick County is a COMCARE Health Home with over 3,000 assigned members. We are located in Wichita, Kansas and have a dedicated team of health home nurse care managers, QMHP care managers and care coordinators who aim to help our members access physical health care, establish wellness and prevention goals and manage their care in a more coordinated fashion. Health Links developed and provides our members with Health Links membership cards so they can share this information during behavioral and physical health visits and emergency room contacts to provide increased opportunity for point-of-service care coordination between treatment team members and Health Links staff. Health risk screening activities have identified that this population is more specialty versus preventive care focused so a primary aim of our team is to connect members with a primary care physician. Following are a couple of success stories.

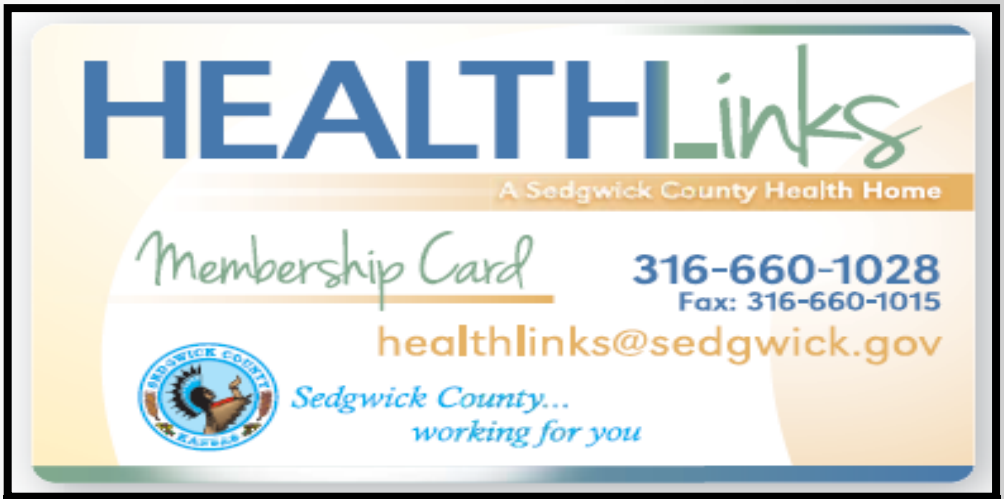
Joe: Health Homes and Beyond

Joe is a 52 year old male with multiple chronic conditions who has had recent back surgery. While working to transition Joe from the hospital to his home following surgery, it became apparent that home health services were not adequate for his recovery. Our Health Link Care Manager spent considerable time gathering relevant information and working with the medical team and MCO to admit Joe to inpatient rehabilitation services which were able to better meet his recovery needs. Without care management services through Health Links, Joe would not have achieved optimal health outcomes, as he was not adequately able to take care of his personal needs in his home. These quick actions also minimized Joe's length of stay in the rehabilitation center, as he was actively involved in discharge planning with his care team and Health Home care manager from point-of-admission to planned discharge from the rehabilitation center.

"Without care management services through Health Homes, Joe would not have achieved optimal health outcomes,..."

Roger: Cutting His Smoking in Half

Roger is 27 years old and participated early on in the completion of an initial health risk screening. However, Roger was reluctant to engage in the development of a Health Action Plan (HAP). The Health Links staff continued to reach out to Roger over the phone and eventually gained Roger's trust.



The staff at Health Links have distributed membership cards to every member on their Health Homes roster. These cards identify them as a Health Home member and have important information for the member's caregivers and other providers.

After a couple of months Roger began to participate in developing health goals for his HAP, including the selection of a Primary Care Physician to oversee his care, getting an eye exam and reducing smoking over time. Establishing a relationship with a medical provider was new to Roger so he asked for assistance from his Care Manager in making the initial calls and indicated he would be more comfortable going to the appointment if his Health Links Care Coordinator attended his initial appointment with him. The Care Coordinator was able to do this, which decreased Roger's anxiety.

Health Links' waiting room contains health literacy tools such as the portion plate and artery visuals displayed above. These hands-on tools are a big hit with the members and offer an opportunity for Health Links staff to engage the member in their own health.

With this assistance, Roger has not only followed through with his first medical appointment, he has also obtained prescription glasses from the optometrist. Even more, with the help of his Health Links Care Coordinator, Roger has reduced his smoking by a half of a pack a day with the goal of reducing this even more!

From the initial goal of just getting engaged in his own healthcare to his reduction in smoking, Roger has benefitted from making goals and working towards them. Roger says without the support of Health Links he would not have scheduled or attended any of these appointments.

For additional information
please visit our website:
http://www.kancare.ks.gov/health_home.htm

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